15. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

a. REFERENCE SUPPLEMENT 2, RULE 5101:3-3-06.

b. REFERENCE IN 4.19-D, RULE 5101:3-3-07.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

a. COVERAGE FOR INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE IS LIMITED TO INPATIENT PSYCHIATRIC SERVICES PROVIDED IN PSYCHIATRIC HOSPITALS AND CERTAIN ALCOHOL AND/OR DRUG ABUSE REHABILITATION HOSPITALS THAT ARE LICENSED BY THE STATE DEPARTMENT OF MENTAL HEALTH OR OPERATED UNDER THE STATE MENTAL HEALTH AUTHORITY.

THIRTY (30) DAY LIMITATION PER SPELL-OF-ILLNESS. A SPELL-OF-ILLNESS BEGINS ON THE DAY OF ADMISSION TO A HOSPITAL AND ENDS 60 DAYS AFTER DISCHARGE. DAYS IN EXCESS OF 30 OR ADDITIONAL HOSPITALIZATIONS BEFORE 60 DAYS HAVE PASSED SINCE A PRIOR HOSPITALIZATION CAN BE COVERED IF CERTIFIED BY A HOSPITAL UR COMMITTEE OR PSRO/PRO AS MEDICALLY NECESSARY. MEDICAL NECESSITY FOR ADMISSION AND CONTINUED STAY MUST BE APPROVED BY THE HOSPITAL UTILIZATION REVIEW COMMITTEE OR ITS DESIGNEE, OR BY A PSRO/PRO. ELECTIVE HOSPITAL ADMISSIONS ARE SUBJECT TO PREADMISSION CERTIFICATION UNLESS ELIGIBILITY IS NOT ESTABLISHED AT THE TIME OF ADMISSION. FOR HOSPITALS PAID ON A PROSPECTIVE BASIS, DAYS NOT APPROVED AS MEDICALLY NECESSARY ARE NOT RECOGNIZED IN DETERMINING WHETHER A CASE QUALIFIES FOR ADDITIONAL OUTLIER PAYMENTS.

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES IS DESCRIBED IN SECTION 4.19-A OF THE STATE PLAN.

EXCEPT FOR HOSPITALS THAT ARE APPROVED BY MEDICARE TO CHARGE PATIENTS A SINGLE RATE THAT COVERS HOSPITAL AND PHYSICIANS' SERVICES, MEDICAID DOES NOT COVER, AS AN INPATIENT SERVICE, THOSE PHYSICIANS' SERVICES FURNISHED TO INDIVIDUAL PATIENTS. IN DETERMINING WHETHER SERVICES ARE COVERED AS A PHYSICIAN SERVICE OR A HOSPITAL SERVICE, MEDICAID USES THE CRITERIA ADOPTED BY THE MEDICARE PROGRAM AS SET FORTH IN 42 CFR 405, SUBPARTS D AND E.

17. Nurse-midwife services

In order to participate in the Ohio Medicaid program, a nurse-midwife must be certified by and registered with the Ohio State Medical Board. If the certified nurse-midwife chooses to bill independently for Medicaid services, he/she must also apply for, and be granted, provider status under Ohio Medicaid.

Ohio Medicaid will make payment for all covered services performed by a certified nurse-midwife which are concerned with the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally and gynecologically.

In addition to the general limitations applicable to all providers and the program limitations for obstetrical services, the following services are noncovered nurse midwifery services under the Ohio Medicaid program except when performed by the certified nurse-midwife in an emergency situation. The nature of the emergency must be documented in the remarks section of the invoice.

1. Delivery, breech version, face presentation

2. Use of forceps

3. Management of acute obstetric emergency

The department will reimburse certified nurse-midwives only for the services personally rendered by the nurse-midwife. For all occasions of service billed, documentation must exist of the billing nurse-midwife's involvement with the service rendered. A counter-signature, alone on the records, is not sufficient. A certified nurse-midwife shall not be reimbursed as an independent provider when the department is required to reimburse another provider for the same service.

18. Hospice care (in accordance with section 1905(o) of the Act).

The Hospice program is an optional benefit for Medicaid recipients who have a terminal illness. Hospice is a philosophy of care that emphasizes the provision of palliative/supportive services in the patient's home. The program is, however, available to Medicaid recipients who reside in NURSING FACILITIES OR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED. Recipients choose Hospice care in lieu of curative care for the terminal illness.

A "hospice" is a public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals. A certified Medicare Hospice provider that meets the Medicare Conditions of Participation for Hospice services can become a provider of Medicaid Hospice services upon execution of the Medicaid provider agreement and approval by the Ohio Department of Human Services (ODHS).

A Medicaid recipient may elect the Hospice benefit if the attending physician and Hospice physician certify that the recipient has six months or less in which to live IF THE ILLNESS RUNS ITS NORMAL COURSE. The recipient or authorized representative must sign an election statement, and by doing so waives his right to regular Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician. ELECTION OF THE HOSPICE BENEFIT SHALL BE FOR THE SAME ENROLLMENT PERIODS AS USED FOR THE MEDICARE HOSPICE BENEFIT PURSUANT TO SECTION 1812(d)(1) OF THE ACT. Individuals dually eligible for Medicare/Medicaid must enroll in the Medicare and Medicaid Hospice program concurrently.

A recipient may revoke the election of Hospice services at any time once an election period. Upon revocation the recipient forfeits Hospice coverage for any remaining days in that election period. The recipient may elect to receive Hospice coverage for any additional period of eligibility.

Every recipient must have a written plan of care developed by the Hospice interdisciplinary team. All covered Hospice services must be consistent with the plan of care. All Hospices participating in the Medicaid Hospice program must provide "core" services performed by Hospice employees. These services include: nursing, physician services, medical social work and counseling.

Other covered Hospice services ("non-core") include:

- Short-term inpatient hospital and respite care.
- Drugs and biologicals used for pain and symtom control.
- Medical supplies and equipment.
- Home health aide and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology.

18. Hospice care (in accordance with section 1905(o) of the Act). (Continued)

- Bereavement counseling for the family.
- Transportation, if needed in order for the recipient to receive medical care for the terminal condition.

Hospices may arrange for another individual or entity to furnish services to Hospice patients. If services are provided under arrangement, the Hospice must assume fiscal and professional management responsibility for those services.

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

TNS # 90-38
SUPERSEDES
TNS # NEW

APPROVAL DATE 10-12-90

EFFECTIVE DATE 7/1/90

20. Extended services to pregnant women

Pregnant women are covered for all Ohio Medicaid services, without limitations, including the 60 days after pregnancy ends.

20-a. Additional Pregnancy-related and postpartum services for 60 days after the pregnancy ends, are provided if indicated by the pregnant woman's physician. These services include case management (see Supplement 1 to Attachment 3.1-A, page 1), extensive counseling and education, and nutritional counseling.

20-b. Additional services for any other medical conditions that may complicate pregnancy include nutritional intervention which may be provided if indicated by the pregnant woman's physician.

TNS # 90-38
SUPERSEDES
TNS # 88-04

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EFFECTIVE DATE 2/1/90

23. Certified Pediatric and Family Nurse Practitioners' Services

Limitations to certified pediatric and family nurse practitioner services are the same as those listed for physician services and are found in Attachment 3.1-A, Item 5.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

23-a. Transportation

Ambulance services are provided only when other means would be detrimental to the patient's health. Covered services include:

1. Emergency services for immediate treatment, including hospital to hospital transfers. The condition of the patient determines whether return to home situation is covered.

2. Transportation to long term care facilities when this is the only form of transportation medically practical.

3. Other ambulance service, including air ambulance, if prior authorized.

Ambulette Services are provided when ambulance service is not required but transportation by auto, bus or other standard methods of transportation are contraindicated.

All prior resources must be utilized. When other types of transportation, such as taxi or bus, is required, the cost is payable from administrative funds.

Transportation services provided by eligible ambulatory health centers and outpatient health facilities are reimbursable.

23-c. Care and Services Provided in Christian Science Sanitoria

Christian Science Sanitoria may participate as long-term care facilities in the Ohio Medicaid program if they are licensed nursing homes and offer only intermediate care facility services.

23-d. Skilled Nursing Services for Patients Under 21 Years of Age

Same as for individuals 21 years of age or older (see Attachment 3.1-A, Pre-Print Page 1, ITEM 4-a).

23-e. Emergency Hospital Services

Provided when necessary to prevent the death or serious impairment of the health of the individual even though the facility does not currently meet the Title XVIII requirements for Medicare or the definitions of inpatient or outpatient hospital services. Applicable for period of emergency only.